CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE
ACUPUNCTURE ADVISORY COUNCIL

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR LICENSURE AS AN ACUPUNCTURE DETOXIFICATION SPECIALIST

INSTRUCTION SHEET

Read all instructions carefully before completing and submitting your application. If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Requirements for All Applicants

The following summarizes the documentation requirements for all applicants. The application form may request additional documentation based on your answers to the questions.

☐ Submit completed, signed and notarized *Application for Licensure as an Acupuncture Detoxification Specialist*.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."
- Applications submitted without this processing fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Arrange for the Board office to receive documentation that you have successfully completed the National Acupuncture Detoxification Association (NADA) auricular point protocol training program.
- Documentation must be sent *directly* from the NADA to the Board office.

☐ Arrange for the Board office to receive verification from the NADA that you are a current member in good standing.
- Verification must be sent *directly* from the NADA to the Board office.

☐ If you were *not* NADA-certified before 7/27/2010, arrange for a "letter of good standing" to be sent to the Board *directly* from *each* jurisdiction where you hold, or have *ever* held, a healthcare license or certificate.
- If you were NADA-certified on or after 7/27/2010, you do not have to provide proof of licensure/certification in a healthcare profession.
- The jurisdiction's seal must be affixed to the verification. Internet or faxed verifications will not be accepted.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

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IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle

2. Other Names Used: _____ _____ _____
   Include maiden, former married, alternate spellings.

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: _____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   daytime or cell fax

7. Enter name and location of the healthcare setting where you will be performing auricular point protocol within a state, federal, or board approved alcohol, substance abuse, or chemical dependency program:

   Practice Name: _____

   Location Address: _____

   _____ DE _____
   City State Zip

EDUCATION & CERTIFICATION INFORMATION

8. Enter the following information about your auricular point protocol training:

PROGRAM NAME	LOCATION	DATES ATTENDED	

Arrange for the Board office to receive documentation that you have successfully completed the NADA auricular point protocol training program, sent directly from NADA to the Board office.

9. Do you have current NADA certification? Yes ☐ No ☐ If yes, enter your certification number: _____

Arrange for the Board office to receive verification *directly* from the NADA that you are a current member.

LICENSURE INFORMATION

10. Do you now hold, or have you *ever* held, a license or certificate in a healthcare-related profession or as an acupuncture detoxification specialist in any jurisdiction (state, District of Columbia or U.S. territory) other than Delaware? Yes ☐ No ☐ If yes, enter information about your licenses:

JURISDICTION	TYPE OF HEALTHCARE LICENSE (e.g., Nurse)	LICENSE/CERTIFICATE NUMBER	EXPIRATION DATE

If you were *not* NADA-certified before 7/27/2010, arrange for a "letter of good standing" to be sent to the Board *directly* from *each* jurisdiction where you hold, or have *ever* held, a healthcare license or certificate.

HEALTH AND DISABILITY

11. Within the two years preceding this application, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as an acupuncture detoxification specialist, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐
    - **If yes, explain on a separate sheet and enclose with this application.**
    - If no, skip to the DISCLOSURES section.

12. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose with this application.**

13. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose with this application.**

DISCLOSURES

14. Have you ever been convicted or entered a plea of guilty or *nolo contendere* (no contest) to any felony or misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐

    Arrange for the Council office to receive a criminal background check.

15. Have you ever had any healthcare related license denied, revoked, suspended or limited or placed on probation? Yes ☐ No ☐ If yes, explain circumstances and outcome. **Attach a copy of the disciplinary order**.
    _____
    _____
    _____

16. Are any disciplinary actions or complaints pending against you before any body that regulates current licensure or certificate in a healthcare related profession? Yes ☐ No ☐ If yes, identify where the action is pending and describe the complaint/action. Include the anticipated date of resolution, if known: _____
    _____
    _____

17. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ If yes, provide a copy of any documents in your possession related to the investigation's final disposition and then continue to Question 18. If no, skip to the DUTY TO REPORT section.

18. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐

DUTY TO REPORT

19. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report all of the following:
    - Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 *Del. C.* §1730(b)(1))
    - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 *Del. C.* §1730(b)(2))
    - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 *Del. C.* §1730 (c))
    - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 *Del. C.* §1731A (f))
    - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 *Del. C.* §1730 (d))
    - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 *Del. C.* §1730 (d))

    I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

    To assure consideration of your license application at the next Council meeting, the Division must receive all of these items no later than 4:30 PM ten full working days before the Council's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within six months of filing may be considered abandoned and discarded.

    Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license.

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I further understand that by filing this application for an Acupuncture Detoxification Specialist in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Board of Medical Licensure and Discipline and Council's Rules and Regulations and to determine that I am physically and mentally capable of engaging in the practice of acupuncture detoxification with safety to the public.

I authorize the Council of the Board of Medical Licensure and Discipline and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Board of Medical Licensure and Discipline any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

APPLICANT SIGNATURE: _____ Date: _____

County of _____ State of _____

Sworn to before me and subscribed in my presence this _____day of _____2_____,

Notary Public: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL NOT BE ACCEPTED.

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd. Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- ☐ Adult Entertainment
- ☐ Deadly Weapons Dealer
- ☐ Dental
- ☐ Medical
- ☐ Nursing
- ☐ Nursing Home Administrator
- ☐ Pharmacy
- ☐ Texas Hold'em Dealer

ENTER FULL CURRENT NAME:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work: _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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